



MEDICAL RELEASE FORM
For Fit Kids Kamp

DEMOGRAPHICS			
Camper's Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: / /
Parent/ Guardian Name:		Primary Phone:	
Emergency Contact:		Emergency Contact Phone:	
Health Insurance Company		Policy#:	Group#:
HEALTH HISTORY (completed by parent/guardian)			
YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/> Allergies to medicine:	<input type="checkbox"/>	<input type="checkbox"/> Hearing aid/loss
<input type="checkbox"/>	<input type="checkbox"/> Allergies to food:	<input type="checkbox"/>	<input type="checkbox"/> Heart Disease/Defect
<input type="checkbox"/>	<input type="checkbox"/> Allergies to stings/bites:	<input type="checkbox"/>	<input type="checkbox"/> Immunizations up-to-date
<input type="checkbox"/>	<input type="checkbox"/> Allergies to other:	<input type="checkbox"/>	<input type="checkbox"/> Major Surgery/Serious Illness
<input type="checkbox"/>	<input type="checkbox"/> Special Diet:	<input type="checkbox"/>	<input type="checkbox"/> Autism
<input type="checkbox"/>	<input type="checkbox"/> Vision Problems:	<input type="checkbox"/>	<input type="checkbox"/> Seizures/Epilepsy/Fainting Spells
<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Asthma
<input type="checkbox"/>	<input type="checkbox"/> Shunts	<input type="checkbox"/>	<input type="checkbox"/> Uses Wheelchair
<input type="checkbox"/>	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/> Communication Problems
<input type="checkbox"/>	<input type="checkbox"/> Emotional/Behavioral Problems	<input type="checkbox"/>	<input type="checkbox"/> Other:
<input type="checkbox"/>	<input type="checkbox"/> Physical Limitations		
Date of most recent tetanus immunization:		/ /	
Medications (please list):			

Signature of Parent or Guardian		Date					
PHYSICAL EXAMINATION (Must be completed by a licensed medical professional)							
Blood Pressure:		Weight:		Height:		BMI:	
Normal	Abnormal	Normal	Abnormal	Normal	Abnormal	Normal	Abnormal
<input type="checkbox"/>	<input type="checkbox"/> Vision	<input type="checkbox"/>	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/> Cranial Nerves		
<input type="checkbox"/>	<input type="checkbox"/> Hearing	<input type="checkbox"/>	<input type="checkbox"/> Respiratory System	<input type="checkbox"/>	<input type="checkbox"/> Coordination		
<input type="checkbox"/>	<input type="checkbox"/> Oral Cavity	<input type="checkbox"/>	<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/> Reflexes		
<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> Genitourinary				
<input type="checkbox"/>	<input type="checkbox"/> Extremities	<input type="checkbox"/>	<input type="checkbox"/> Skin				
Other:							
<input type="checkbox"/> Yes <input type="checkbox"/> No I have performed the above examination and certify that the patient may participate in Camp.							
Examiner's Signature (required):							
Date of Exam (required): / /							
Examiner's Printed Name:				Clinic Name:			
Address:				Phone:			
***"Healthier You" Camp is going to be a very active camp, where kids will be participating in swimming, aerobics, rock climbing, yoga , dance, fitness runs and various exercise routines daily. The participant must be able to be actively involved in all of the activities.							